EXHIBIT F

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Dawn Stehle

CONTACT PERSON Brian Jones

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PHONE NO. 501-537-2064 **FAX NO.** 501-404-4619 **E-MAIL** Brian.Jones@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? State Plan Amendment # 2015-006 and Hospital 9-15

2. What is the subject of the proposed rule? Amendment of Arkansas Code § 20-77-190 2(b)

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? _____

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒

If yes, please provide a brief summary explaining the regulation.

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The purpose of the prosed rule is to change the Upper Payment Limit (UPL) calculations procedure to use the most recently submitted cost report as of June 30 if the audited cost report is over two years old.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
November 13, 2015

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
January 1, 2016 (Federally Mandated August 1, 2015)

12. Do you expect this rule to be controversial? Yes ☐ No ☒

If yes, please explain. _____

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

There should be no provider comment against this rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE NO. 501-537-2064 **FAX NO.** 501-404-4619 **EMAIL:** Brian.Jones @ dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE State Plan Amendment # 2015-006 and Hospital 9-15

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue		General Revenue	
Federal Funds	($32,328,163)	Federal Funds	($32,120,990)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)	($13,710,235)	Other (Identify)	($13,917,408)
Total	($46,038,398)	Total	($46,038,398)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ ($13,710,235)

Next Fiscal Year
$ ($13,917,408)

The budget impact of using current data shows a savings for both the Federal portion and a reduction in the assessment fee or intergovernmental transfer (IGT) paid by the hospitals. There is no budget impact for the State as the Hospital Assessment Fee or IGT pays the match on the federal funds.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Summary for State Plan Amendment #2015-006 & Hospital 9-15

Due to an Amendment of Arkansas Code § 20-77-1902(b); the Arkansas Department of Human Services, Medical Assistance Program Cost Reimbursement Rules for hospital access payments and assessment fees are being amended. Effective August 1, 2015 and forward the state will begin using the most recently submitted hospital cost reports unless the audited cost report is less than 2 years old to calculate the annual access payments and assessment fees. The budget impact of using more current data is estimated to be a savings of $46,038,398. There is no budget impact to Arkansas Department of Human Services as the match is paid through provider assessment fees or intergovernmental transfer provided by the hospitals.

250.629 Outpatient Hospital Access Payments ~~11-15-12~~1-1-16

All Arkansas private hospitals (that is, all hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private rehabilitative and specialty hospitals, qualify for a private hospital outpatient access payment.

The outpatient access payment shall be equal to each eligible hospital's share of a funding pool, pro-rated based on the hospital's paid claims adjudicated for outpatient hospital services. The amount of the funding pool shall be determined annually by Arkansas Medicaid based on available funding.

The access payments shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital access payment funding pool by using the Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of Medicaid-based payments and the Medicaid outpatient hospital services cost.

B. For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the Medicaid paid claims adjudicated for outpatient hospital services for the most recent audited fiscal period.

1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for access payment purposes.
2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
3. In order to be used to calculate the access payment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the payments will be made.
4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
5. For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their access payments, provided that such hospitals were licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated access payments based on the partial year data.

C. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the hospital's Medicaid paid claims adjudicated for outpatient hospital services divided by the total Medicaid paid claims adjudicated for outpatient hospital services of all eligible hospitals.

D. Outpatient hospital access payments shall be paid on a quarterly basis.

E. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.628 Inpatient Hospital Access Payments ~~11-15-121-~~ 1-16

All Arkansas private hospitals (that is, all hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private rehabilitative and specialty hospitals, qualify for a private hospital inpatient access payment.

The inpatient access payment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid based on available funding.

The access payments shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital access payment funding pool. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals will not exceed 97% of the difference between the Medicaid UPL and the Medicaid-based payments.

B. For each private hospital eligible for the access payment, Arkansas Medicaid shall determine the number of Medicaid discharges for the most recent audited fiscal period.

1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period.
2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
3. In order to be used to calculate the access payments, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the payments will be made.
4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
5. For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their access payment, provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated payments based on the partial year data.

C. To the extent that this private hospital access payment results in payments in excess of the upper payment limit, such payments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

D. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges of all eligible hospitals.

E. The amount of each eligible hospital's access payment shall be its pro rata percentage multiplied by the amount of available funding for the inpatient hospital access payment pool as determined by Arkansas Medicaid.

F. Inpatient hospital access payments shall be made on a quarterly basis.

G. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

D. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.626 In-State Private Pediatric Inpatient Adjustment ~~11-15-121-~~ 1-16

All Arkansas private pediatric hospitals qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited final year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare-related upper payment limit specified in 42 C.F.R § 447.727.

If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.627 Non-State Government Owned or Operated Outpatient UPL Reimbursement Adjustment ~~11-15-121-~~ 1-16

Arkansas non-state government-owned or operated acute care/general hospitals (that is, all acute care government hospitals within the state of Arkansas that are neither owned nor operated by the State of Arkansas) shall qualify for an annual upper payment limit (UPL) reimbursement adjustment. Psychiatric hospitals, pediatric hospitals, rehabilitative hospitals and critical access hospitals are not eligible for an adjustment. Payment shall be made before the end of the state fiscal year (SFY). The adjustment will be calculated and based on each hospital's previous SFY outpatient Medicare-related upper payment limit (UPL as specified in 42 CFR 447.321) for Medicaid reimbursed outpatient services. The adjustments will be calculated as follows:

A. For each qualifying hospital, Arkansas Medicaid will annually identify the total Medicaid outpatient expenditures during the most recent completed SFY.

B. For each qualifying hospital, the total Medicaid expenditures are determined in step A, and are divided by 80% to estimate the amount that would have been paid using Medicare reimbursement principles.

C. The difference between step A identified Medicaid expenditures and step B estimated Medicare amounts is the UPL annual adjustment amount that will be reimbursed.

Eligible hospitals that were not licensed and providing services throughout the most recent completed SFY shall receive a pro-rated adjustment based on the partial year data.

D. Payment for SH+FY 2003 shall be pro-rated proportional to the number of days between April 1, 2003 and June 30, 2003 to the total number of days in SFY 2003.

E. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

F. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

hospitals located outside of Arkansas (that is, acute care hospitals outside of Arkansas that are neither owned nor operated by any state) that: a) Provide level 1 trauma and burn care services; b) Provide level 3 neonatal care services; c) Are obligated to serve all patients, regardless of the patient's state of origin; d) Are located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 states, including Arkansas; e) Serve as a tertiary care provider for patients residing within a 125 mile radius; and f) Meet the criteria for disproportionate share hospital under Section 1923 of the Social Security Act in at least one state other than the state in which the hospital is located.

The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.

A. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate

   1. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

   2. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.

   3. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.

   4. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.

   5. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

   6. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.

   7. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.

   1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.

   2. The result shall be the adjusted Medicare per discharge rate.

   3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.

   4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

A. The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.

1. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate

a. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

b. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.

c. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.

d. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.

2. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

3. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.

4. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.

1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.

2. The result shall be the adjusted Medicare per discharge rate.

3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

D. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.625 Inpatient Adjustment for Non-State Public Hospitals Outside Arkansas ~~7-1-06~~1-1-16

Effective April 1, 2006 through December 31, 2006, Arkansas may provide a public inpatient rate adjustment to non-state government owned or operated acute care regional medical center

Mark up

TOC not required

250.622 Arkansas State Operated Teaching Hospital Adjustment ~~6-1-06~~1-1-16

Effective May 9, 2000, Arkansas State Operated Teaching Hospitals qualify for an inpatient rate adjustment.

A. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit.

B. The adjustment is calculated as follows:

1. Using the most current audited data, Arkansas Medicaid determines each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per-discharge rate.
    a. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
    b. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
    c. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.
2. The base per-discharge rates are trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per-discharge rates have been trended forward, the Medicare per-discharge rate is divided by the Medicare case mix index and the Medicaid per-discharge rate is divided by the Medicaid case mix index.
    a. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients.
    b. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per-discharge rate is subtracted from the base Medicare per discharge rate.
5. The difference is multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference is multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year.
7. The result is the amount of the annual State Operated Teaching Hospital Adjustment.
8. Payment is made on an annual basis before the end of the state fiscal year (June 30).
9. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.624 Non-State Public Hospital Inpatient Adjustment ~~6-1-06~~1-1-16

All Arkansas non-state government-owned or operated acute care and critical access hospitals (that is, all acute care and critical access government hospitals within the state of Arkansas that are neither owned nor operated by the state of Arkansas) shall qualify for a public hospital inpatient rate adjustment.

250.629 Outpatient Hospital Access Payments 1-1-16

All Arkansas private hospitals (that is, all hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private rehabilitative and specialty hospitals, qualify for a private hospital outpatient access payment.

The outpatient access payment shall be equal to each eligible hospital's share of a funding pool, pro-rated based on the hospital's paid claims adjudicated for outpatient hospital services. The amount of the funding pool shall be determined annually by Arkansas Medicaid based on available funding.

PROPOSED

The access payments shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital access payment funding pool by using the Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of Medicaid-based payments and the Medicaid outpatient hospital services cost.

B. For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the Medicaid paid claims adjudicated for outpatient hospital services for the most recent audited fiscal period.

   1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for access payment purposes.

   2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.

   3. In order to be used to calculate the access payment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1st of the state fiscal year (SFY) for which the payments will be made.

   4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

   5. For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their access payments, provided that such hospitals were licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated access payments based on the partial year data.

C. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the hospital's Medicaid paid claims adjudicated for outpatient hospital services divided by the total Medicaid paid claims adjudicated for outpatient hospital services of all eligible hospitals.

D. Outpatient hospital access payments shall be paid on a quarterly basis.

E. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.628 Inpatient Hospital Access Payments 1-1-16

All Arkansas private hospitals (that is, all hospitals within the state of Arkansas that are neither owned nor operated by state or local government), with the exception of private rehabilitative and specialty hospitals, qualify for a private hospital inpatient access payment.

The inpatient access payment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid based on available funding.

PROPOSED

The access payments shall be calculated as follows:

A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital access payment funding pool. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals will not exceed 97% of the difference between the Medicaid UPL and the Medicaid-based payments.

B. For each private hospital eligible for the access payment, Arkansas Medicaid shall determine the number of Medicaid discharges for the most recent audited fiscal period.

1. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period.
2. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
3. In order to be used to calculate the access payments, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the payments will be made.
4. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
5. For hospitals that filed a partial year cost report for the most recently audited cost report year, such partial year cost report data shall be annualized to determine their access payment, provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report year shall receive pro-rated payments based on the partial year data.

C. To the extent that this private hospital access payment results in payments in excess of the upper payment limit, such payments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

D. For each eligible private hospital, Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges of all eligible hospitals.

E. The amount of each eligible hospital's access payment shall be its pro rata percentage multiplied by the amount of available funding for the inpatient hospital access payment pool as determined by Arkansas Medicaid.

F. Inpatient hospital access payments shall be made on a quarterly basis.

G. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

D. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

PROPOSED

250.626 In-State Private Pediatric Inpatient Adjustment 1-1-16

All Arkansas private pediatric hospitals qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited final year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare-related upper payment limit specified in 42 C.F.R § 447.727.

If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.627 Non-State Government Owned or Operated Outpatient UPL Reimbursement Adjustment 1-1-16

Arkansas non-state government-owned or operated acute care/general hospitals (that is, all acute care government hospitals within the state of Arkansas that are neither owned nor operated by the State of Arkansas) shall qualify for an annual upper payment limit (UPL) reimbursement adjustment. Psychiatric hospitals, pediatric hospitals, rehabilitative hospitals and critical access hospitals are not eligible for an adjustment. Payment shall be made before the end of the state fiscal year (SFY). The adjustment will be calculated and based on each hospital's previous SFY outpatient Medicare-related upper payment limit (UPL as specified in 42 CFR 447.321) for Medicaid reimbursed outpatient services. The adjustments will be calculated as follows:

A. For each qualifying hospital, Arkansas Medicaid will annually identify the total Medicaid outpatient expenditures during the most recent completed SFY.

B. For each qualifying hospital, the total Medicaid expenditures are determined in step A, and are divided by 80% to estimate the amount that would have been paid using Medicare reimbursement principles.

C. The difference between step A identified Medicaid expenditures and step B estimated Medicare amounts is the UPL annual adjustment amount that will be reimbursed.

Eligible hospitals that were not licensed and providing services throughout the most recent completed SFY shall receive a pro-rated adjustment based on the partial year data.

D. Payment for SH+FY 2003 shall be pro-rated proportional to the number of days between April 1, 2003 and June 30, 2003 to the total number of days in SFY 2003.

E. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

F. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

hospitals located outside of Arkansas (that is, acute care hospitals outside of Arkansas that are neither owned nor operated by any state) that: a) Provide level 1 trauma and burn care services; b) Provide level 3 neonatal care services; c) Are obligated to serve all patients, regardless of the patient's state of origin; d) Are located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 states, including Arkansas; e) Serve as a tertiary care provider for patients residing within a 125 mile radius; and f) Meet the criteria for disproportionate share hospital under Section 1923 of the Social Security Act in at least one state other than the state in which the hospital is located.

The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.

A. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate

1. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.
2. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
3. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
4. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.
5. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.
6. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.
7. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.

1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.
2. The result shall be the adjusted Medicare per discharge rate.
3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.
4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

A. The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 CFR § 447.272. The adjustment shall be calculated as follows.

1. Using data from the hospital's most recent audited cost report, Arkansas Medicaid shall determine each eligible non-state public hospital's base Medicare per discharge rate and its base Medicaid per discharge rate

a. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

b. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.

c. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.

d. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.

2. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

3. For a hospital that, for the most recent audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine the hospital's rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year.

4. Hospitals with partial year cost reports which were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

B. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 CFR § 447.272 for non-state government owned or operated hospitals.

1. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent.

2. The result shall be the adjusted Medicare per discharge rate.

3. The base Medicaid per discharge rate shall then be subtracted from the adjusted Medicare per discharge rate.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

C. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

D. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.625 Inpatient Adjustment for Non-State Public Hospitals Outside Arkansas **1-1-16**

Effective April 1, 2006 through December 31, 2006, Arkansas may provide a public inpatient rate adjustment to non-state government owned or operated acute care regional medical center

TOC not required

250.622 Arkansas State Operated Teaching Hospital Adjustment 1-1-16

Effective May 9, 2000, Arkansas State Operated Teaching Hospitals qualify for an inpatient rate adjustment.

A. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit.

B. The adjustment is calculated as follows:

PROPOSED

1. Using the most current audited data, Arkansas Medicaid determines each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per-discharge rate.
    a. Arkansas Medicaid will use the date of the Medicaid Notice of Provider Reimbursement (NPR) received by the Division of Medical Services from the Medicare Intermediary to determine the most recent audited cost report period for rate adjustment purposes.
    b. The most current audited cost report period is used when an earlier period's NPR is finalized after a later period's.
    c. In order to be used to calculate the rate adjustment amount, the Medicaid NPR received from the Medicare Intermediary must be dated before July 1 of the state fiscal year (SFY) for which the adjustment payments will be made.
2. The base per-discharge rates are trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per-discharge rates have been trended forward, the Medicare per-discharge rate is divided by the Medicare case mix index and the Medicaid per-discharge rate is divided by the Medicaid case mix index.
    a. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients.
    b. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per-discharge rate is subtracted from the base Medicare per discharge rate.
5. The difference is multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference is multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year.
7. The result is the amount of the annual State Operated Teaching Hospital Adjustment.
8. Payment is made on an annual basis before the end of the state fiscal year (June 30).
9. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

250.624 Non-State Public Hospital Inpatient Adjustment 1-1-16

All Arkansas non-state government-owned or operated acute care and critical access hospitals (that is, all acute care and critical access government hospitals within the state of Arkansas that are neither owned nor operated by the state of Arkansas) shall qualify for a public hospital inpatient rate adjustment.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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501-320-6428 · Fax: 501-404-4619
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TO: Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)

EFFECTIVE DATE: January 1, 2016

SUBJECT: Provider Manual Update Transmittal HOSPITAL-9-15

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
250.622	6-1-06	250.622	1-1-16
250.624	6-1-06	250.624	1-1-16
250.625	7-1-06	250.625	1-1-16
250.626	11-15-12	250.626	1-1-16
250.627	11-15-12	250.627	1-1-16
250.628	11-15-12	250.628	1-1-16
250.629	11-15-12	250.629	1-1-16

Explanation of Updates

Sections 250.622, 250.624, 250.625, 250.626, 250.627, 250.628 and 250.629 are updated with current cost report information.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle/TAH

Dawn Stehle
Director

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: ~~July 1, 2009~~August 1, 2015

2.a. Outpatient Hospital Services (continued)

Outpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009, all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901 (7) (D) and (E) shall be eligible to receive outpatient hospital access payments. The outpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid outpatient hospital payments. The outpatient hospital access payments shall be determined on the basis of cost and calculated as follows:

1. For each rate year the state shall identify, on the basis of paid claims adjudicated through the State's MMIS, reimbursement for outpatient hospital services that were delivered by the private hospitals eligible for this supplemental payment.
2. The state shall estimate the amount of cost for the same dates of service identified in step one using Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The State will utilize cost data in a manner approved by CMS.
3. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of step one (Medicaid based payment) and results of step two (Medicaid outpatient hospital services cost).
4. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals identified in step three shall be divided by the total Medicaid outpatient hospital services base payment for eligible hospitals identified in step one to arrive at an adjustment percentage. This percentage will be calculated annually.
5. Each eligible hospital's outpatient hospital access payment shall be determined by multiplying the Medicaid outpatient hospital services payment identified in step one by the adjustment factor determined in step four. The current year's adjustment will be based on cost data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Outpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their outpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015 and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Outpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

(2) Pediatric Hospitals

Effective for claims with dates of service on or after April 1, 1992, outpatient hospital facility services provided at a pediatric hospital will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed based on Medicare cost rules in effect prior to the September 29, 1989, rule change.

1. Inpatient Hospital Services (continued)

Inpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009 all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901(7)(D) and (E) shall be eligible to receive inpatient hospital access payments. The inpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid inpatient hospital payments.

1. For each rate year, the state shall determine for each hospital and in total the number of Medicaid inpatient discharges for private hospitals eligible for this supplemental payment.
2. For each rate year, the state shall identify, on the basis of paid inpatient discharge claims adjudicated through the State's MMIS, reimbursement for inpatient hospital services that were delivered by the private hospitals identified in step one.
3. The state shall estimate the amount that would have been paid for the services identified in step two using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related UPL. ~~in the same manner as is approved by CMS and described in the Private Hospital Inpatient Adjustment section of this Attachment.~~
4. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals shall not exceed 97% of the difference between the results of step three (Medicare UPL) and results of step two (Medicaid based payment).
5. Using discharge data identified in step one, the state shall determine each eligible hospital's pro rata percentage which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges for all eligible hospitals. This percentage will be calculated annually.
6. Each eligible hospital's inpatient hospital access payment shall be determined by multiplying the ~~maximum allowable~~ aggregate inpatient access payment identified in step 4 by the pro rata percentage identified in step 5. The current year's adjustment will be based on discharge data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Inpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their inpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015 and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Inpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

1. Inpatient Hospital Services (Continued)

Private Pediatric Hospital Inpatient Adjustment

Effective April 19, 2001, all private pediatric hospitals within the state of Arkansas as previously defined in this section of Attachment 4.19-A shall qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited fiscal year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare related upper payment limit specified in 42 C.F.R. 447.272.

Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

Effective August 1, 2015 and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: ~~July 1, 2005~~August 1, 2015

1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment (continued)

3. The base Medicaid per discharge rate shall be subtracted from the adjusted Medicare per discharge rate determined pursuant to step 2.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

Effective August 1, 2015 and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30, for the Non-State Public Hospital Adjustment. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

Mark Up

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(d) Physicians/Administrative/Teachers will be included in costs as recognized by Medicare HIM-15 reimbursement principles.

(e) Arkansas State Operated Teaching Hospital Adjustment: Effective May 9, 2000, Arkansas State Operated Teaching Hospitals shall qualify for an inpatient rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit. The adjustment shall be calculated as follows:

1. Using the most current audited data, Arkansas shall determine each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per discharge rate.
2. The base per discharge rates shall be trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per discharge rates have been trended forward, the Medicare per discharge rate will be divided by the Medicare case mix index and the Medicaid per discharge rate will be divided by the Medicaid case mix index. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per discharge rate shall be subtracted from the base Medicare per discharge rate.
5. The difference shall be multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year. The result shall be the amount of the annual State Operated Teaching Hospital Adjustment.
7. Payment shall be made on an annual basis before the end of the state fiscal year.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

Any costs associated with heart, liver, non-experimental bone marrow, lung and skin transplants will not be reimbursed through a cost settlement. Refer to Attachment 4.19-A, Page 3, for the reimbursement methodology for these procedures.

2.a. Outpatient Hospital Services (continued)

Outpatient Hospital Access Payments

PROPOSED

Effective for services provided on or after July 1, 2009, all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901 (7) (D) and (E) shall be eligible to receive outpatient hospital access payments. The outpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid outpatient hospital payments. The outpatient hospital access payments shall be determined on the basis of cost and calculated as follows:

1. For each rate year the state shall identify, on the basis of paid claims adjudicated through the State's MMIS, reimbursement for outpatient hospital services that were delivered by the private hospitals eligible for this supplemental payment.
2. The state shall estimate the amount of cost for the same dates of service identified in step one using Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The State will utilize cost data in a manner approved by CMS.
3. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of step one (Medicaid based payment) and results of step two (Medicaid outpatient hospital services cost).
4. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals identified in step three shall be divided by the total Medicaid outpatient hospital services base payment for eligible hospitals identified in step one to arrive at an adjustment percentage. This percentage will be calculated annually.
5. Each eligible hospital's outpatient hospital access payment shall be determined by multiplying the Medicaid outpatient hospital services payment identified in step one by the adjustment factor determined in step four. The current year's adjustment will be based on cost data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Outpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their outpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Outpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

(2) Pediatric Hospitals

Effective for claims with dates of service on or after April 1, 1992, outpatient hospital facility services provided at a pediatric hospital will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed based on Medicare cost rules in effect prior to the September 29, 1989, rule change.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: August 1, 2015

1. Inpatient Hospital Services (continued)

PROPOSED

Inpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009 all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901(7)(D) and (E) shall be eligible to receive inpatient hospital access payments. The inpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid inpatient hospital payments.

1. For each rate year, the state shall determine for each hospital and in total the number of Medicaid inpatient discharges for private hospitals eligible for this supplemental payment.
2. For each rate year, the state shall identify, on the basis of paid inpatient discharge claims adjudicated through the State's MMIS, reimbursement for inpatient hospital services that were delivered by the private hospitals identified in step one.
3. The state shall estimate the amount that would have been paid for the services identified in step two using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related UPL.
4. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals shall not exceed 97% of the difference between the results of step three (Medicare UPL) and results of step two (Medicaid based payment).
5. Using discharge data identified in step one, the state shall determine each eligible hospital's pro rata percentage which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges for all eligible hospitals. This percentage will be calculated annually.
6. Each eligible hospital's inpatient hospital access payment shall be determined by multiplying the aggregate inpatient access payment identified in step 4 by the pro rata percentage identified in step 5. The current year's adjustment will be based on discharge data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Inpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their inpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Inpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

1. Inpatient Hospital Services (Continued)

Private Pediatric Hospital Inpatient Adjustment

Effective April 19, 2001, all private pediatric hospitals within the state of Arkansas as previously defined in this section of Attachment 4.19-A shall qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited fiscal year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare related upper payment limit specified in 42 C.F.R. 447.272.

Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

PROPOSED

1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment (continued)

3. The base Medicaid per discharge rate shall be subtracted from the adjusted Medicare per discharge rate determined pursuant to step 2.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30, for Non-State Public Hospital Adjustment. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

PROPOSED

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(d) Physicians/Administrative/Teachers will be included in costs as recognized by Medicare HIM-15 reimbursement principles.

(e) Arkansas State Operated Teaching Hospital Adjustment: Effective May 9, 2000, Arkansas State Operated Teaching Hospitals shall qualify for an inpatient rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit. The adjustment shall be calculated as follows:

1. Using the most current audited data, Arkansas shall determine each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per discharge rate.
2. The base per discharge rates shall be trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per discharge rates have been trended forward, the Medicare per discharge rate will be divided by the Medicare case mix index and the Medicaid per discharge rate will be divided by the Medicaid case mix index. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per discharge rate shall be subtracted from the base Medicare per discharge rate.
5. The difference shall be multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year. The result shall be the amount of the annual State Operated Teaching Hospital Adjustment.
7. Payment shall be made on an annual basis before the end of the state fiscal year.

PROPOSED

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

Any costs associated with heart, liver, non-experimental bone marrow, lung and skin transplants will not be reimbursed through a cost settlement. Refer to Attachment 4.19-A, Page 3, for the reimbursement methodology for these procedures.